

**Thank you for participating in this CME activity. The Office of Continuing Medical Education would like to know if this was a valuable learning experience for you, and would appreciate your responses to the following questions.**

Title of Activity \_\_\_\_\_

Date \_\_\_\_\_

	1=Poor	2=Below Average	3=Average	4=Above Average	5=Outstanding
<b>1. Presenter: __</b>					
To what extent was the presenter knowledgeable, organized and effective in his/her presentation?	1	2	3	4	5
<b>Presenter: __</b>					
To what extent was the presenter knowledgeable, organized and effective in his/her presentation?	1	2	3	4	5
<b>2. How might the format of this activity be improved in order to be most appropriate for the content presented (select all that apply)?</b>					
Format was appropriate; no changes needed	<input type="checkbox"/>	Add a hands-on instructional component			<input type="checkbox"/>
Include more case-based presentations	<input type="checkbox"/>	Schedule more time for Q and A			<input type="checkbox"/>
Increase interactivity with attendees	<input type="checkbox"/>	Other, describe			<input type="checkbox"/>
Add breakouts for subtopics	<input type="checkbox"/>				
<b>3. Please rate the projected impact of the presentation objectives on:</b>					
		<b>Not Applicable</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>No Impact</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Moderate Impact</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>High Impact</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>4. Did you have the opportunity to discuss practice-relevant issues with the speakers?</b>	YES <input type="checkbox"/>		NO <input type="checkbox"/>		
<b>5. How will you change your practice as a result of attending this activity (select all that apply)?</b>					
<input type="checkbox"/> Create/revise protocols, policies, and/or procedures	<input type="checkbox"/> This activity validated my current practice				
<input type="checkbox"/> Change the management and/or treatment of my patients	<input type="checkbox"/> I will not make any changes to my practice				
<input type="checkbox"/> Other, please specify:					
<b>6. Was there any apparent conflict of interest shown by the speaker(s)? If yes, please explain</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
<b>7. Was the meeting room conducive to learning?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
<b>General Comments:</b>					
<b>E-mail</b> address to participate in an outcome-measured post evaluation activity:					
Specialty :	<input type="checkbox"/> MD/DO	<input type="checkbox"/> RN	<input type="checkbox"/> PA	<input type="checkbox"/> Student	<input type="checkbox"/> Other health professional